2

03-649

No.

Supreme Court, U.S.
FILED
NOV 26 2003
OFFICE OF THE CLERK

IN THE
SUPREME COURT OF THE UNITED STATES

CIGNA HEALTHCARE OF FLORIDA,
Petitioner,

v.

ROBBIE LEE LAND AND
DONNA LAND,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

NORWOOD S. WILNER
STEPHANIE J. HARTLEY
Spohrer, Wilner, Maxwell
& Matthews, P.A.
701 West Adams Street
Jacksonville, FL 32204
(904) 354-8310
Counsel for Respondent

52 pp

QUESTION PRESENTED

Whether § 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a), completely preempts a state-law tort claim for damages against an ERISA- governed health plan, when the damages were caused by a negligent medical decision.

PARTIES TO THE PROCEEDING

Respondents Robbie Lee Land and Donna Land were Plaintiffs-appellants in the appeal below. Petitioner CIGNA HealthCare of Florida, Inc. was defendant-appellant. Respondent Robbie Lee Land was misidentified in the Petition as "Robbie Land Lee."

TABLE OF CONTENTS

QUESTION PRESENTED i

PARTIES TO THE PROCEEDING ii

TABLE OF CONTENTS iii

TABLE OF AUTHORITIES iv

OPPOSITION TO WRIT OF CERTIORARI 1

OPINIONS BELOW 1

JURISDICTION 1

STATUTES AND CONSTITUTIONAL PROVISIONS INVOLVED 1

STATEMENT OF THE CASE 2

- **Introduction** 2
- **Facts Of The Case** 3
- **CIGNA Mischaracterizes Certain Facts And Misconstrues The Eleventh Circuit Court's Opinion Below** 5

REASONS FOR DENYING THE WRIT 6

CONCLUSION 10

TABLE OF AUTHORITIES

Cases:

Land v. Cigna HealthCare,
339 F.3d 1286 (11th Cir. 2003) 8, 10

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 115 S.Ct. 1671,
131 L.Ed.2d 695 (1995) 9

Pappas v. Asbel, 768 A.2d 1089 (Pa. 2001) 8-10

Pegram v. Herdrich, 530 U.S. 211 (2000) 2, 4, 6, 8-10

Pilot Life Insurance Co., v. Dedeaux,
481 U.S. 41 (1987) 6

United States Healthcare Sys. Of Penn., Inc. v. Penn. Hosp. Ins. Co.,
530 U.S. 1241 (1998) 9

Statutes:

28 U.S.C. § 1254(1) 1, 2, 4, 7, 9, 10

28 U.S.C. § 1291 9

28 U.S.C. § 1331 8-10

28 U.S.C. § 1331 . . . . . 2, 4, 6, 8-10

29 U.S.C. § 1132 6

29 U.S.C. §§ 1001 et. seq 9

Rules:

F.R.C.P. 12(b)(6) 4

OPPOSITION TO WRIT OF CERTIORARI

Respondents Robbie Lee Land and Donna Land oppose Petitioner's request for a writ of certiorari and respectfully ask this Court to deny the petition and allow the judgment of the United States Court of Appeals for the Eleventh Circuit to stand.

OPINIONS BELOW

The opinion of the Court of Appeals (App. 1a) is reported at *Land v. Cigna HealthCare*, 339 F.3d 1286 (11th Cir. 2003). The memorandum opinion and order of the United States District Court for the Middle District of Florida denying Respondent Land's motion to remand and dismissing the complaint with prejudice (App. 16a) is unreported.

JURISDICTION

This Court has jurisdiction under 28 U.S.C. § 1254(1). The court of appeals had jurisdiction to review the district court's final judgment pursuant to 28 U.S.C. § 1291. Whether the district court ever had jurisdiction under either 28 U.S.C. § 1331 or 29 U.S.C. § 1132, as asserted in Petitioner's jurisdictional statement, is precisely the question answered in the **negative** by the court of appeals. Respondents assert that the district court did not have jurisdiction in this case.

STATUTES AND CONSTITUTIONAL PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution provides: "This Constitution, and the laws which

shall be made in pursuance thereof...shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any thing in the Constitution of laws of any State to the contrary notwithstanding." U.S. Const. Art VI, cl. 2. The pertinent provisions of ERISA, 29 U.S.C. §§ 1001 et seq., are set forth in the appendix.

STATEMENT OF THE CASE

Introduction

This case follows on the heels of five petitions raising a similar issue; *Aetna Health inc. v. Davila*, No. 02-1845 (consolidated with *Calad*, petition granted November 3, 2003), *CIGNA HealthCare of Texas v. Calad*, No. 03-83 (consolidated with *Davila*, petition granted November 3, 2003), *Vytra Healthcare v. Cicio*, No. 03-69 (petition filed July 11, 2003), *Conover v. Aetna U.S. Healthcare, Inc.*, No. 02-1864 (petition filed June 17, 2003), and *Roark v. Humana, Inc.*, No. 02-1826 (petition dismissed September 18, 2003).

Here, the Eleventh Circuit Court of Appeals held that the district court did not have jurisdiction over Land's state law medical malpractice claim against his HMO, because Land's claims were not preempted by ERISA § 502 (a)(1)(B). Following this Court's reasoning in *Pegram v. Herdrich*, 530 U.S. 211 (2000), the court of appeals recognized that complete ERISA preemption under § 502 (a) simply does not apply in cases involving medical decisions by HMO's. *Land*, 339 F.3d 1286. In essence, the court held that because Respondent had no recourse under ERISA § 502(a), his claim was not preempted and the district court, therefore, had no jurisdiction.

Despite Petitioner's efforts to muddy the waters, this case presents the relatively straightforward question of whether an HMO can be held accountable under state tort law when its negligent medical decisions cause injuries. As the Eleventh Circuit established, the facts here demonstrate why that question should be answered in the affirmative.

Facts Of The Case

1. Robbie Lee Land was bitten by his cat on the middle finger of his left hand. By the next day, Land's entire hand had become swollen and inflamed, and he sought medical treatment. Land was treated by a CIGNA-approved emergency room physician, who diagnosed Land's condition as cellulitis (a relatively localized infection) and prescribed antibiotics. Land's condition had not improved by the next day, and his physician began to suspect that Land was actually suffering from osteomyelitis, a much more serious infection than cellulitis. Land's original physician consulted with another CIGNA-approved physician, and the two doctors determined that an immediate, aggressive course of anti-biotics along with constant monitoring and evaluation, provided on an in-patient basis, was the most appropriate treatment of Land's osteomyelitis. Land was admitted to the hospital that day, and intravenous anti-biotic treatment was initiated.

On the afternoon of the day Land was admitted to the hospital, a CIGNA approval *nurse* reviewed the proposed treatment plan for Land's infection. The nurse, without any consultation or discussion with Land's treating physicians, decided that the correct diagnosis of Land's condition was only

a localized infection and ordered him discharged from the hospital, with anti-biotic treatment to be provided on an out-patient, rather than an in-patient, basis. Land's condition worsened dramatically, and he was eventually diagnosed with osteomyelitis, as his two original physicians suspected. Following a series of surgeries, Land was forced to undergo amputation of his entire left, middle finger.

2. Based on the approval nurse's patient-specific medical decision regarding Land's condition and treatment, Land filed a medical malpractice suit in state court. CIGNA removed the case to the federal district court pursuant to federal question jurisdiction 28 U.S.C. § 1331 and ERISA preemption under 29 U.S.C. §§ 1001 et. seq. The district court denied Land's motion for remand to state court and dismissed the case upon CIGNA's F.R.C.P. 12(b)(6) motion though, as the court of appeals noted, the district court's reason for granting the dismissal was not stated in its order. App at 4a. Land's appeal to the Eleventh Circuit Court of Appeals followed.

The Eleventh Circuit vacated the district court's dismissal and ordered the case remanded to state court. The court of appeals relied heavily on this Court's decision in *Pegram*, 530 U.S. 211, which held that medical decisions, which the court determined occurred here, were not fiduciary decisions and did not fall within the ambit of ERISA preemption. *Land*, 339 F.3d 1286. The petition for a writ of certiorari timely followed the Eleventh Circuit's ruling.

CIGNA Mischaracterizes Certain Facts And Misconstrues The Eleventh Circuit Court's Opinion Below

1. Petitioners describe the Eleventh Circuit's opinion as failing to recognize the importance of the statutory scheme created by Congress with ERISA. Petitioners simultaneously misstate the true nature of the CIGNA nurse's decision as having been merely an "improper benefits determination." Pet. at 2. On the contrary, the Eleventh Circuit determined that the nurse's decision here was a patient-specific, medical decision, and thus fell outside the bounds of ERISA preemption.

Moreover, CIGNA incorrectly describes Land's admission to the hospital for inpatient treatment as having been "at his request." Pet. at 3. Describing Land's hospital admission as a request gives the impression that it was elective on Land's part. In fact, as the Eleventh Circuit pointed out, Land's immediate admission to the hospital was "ordered" by two CIGNA physicians. App. at 3a. Thus, rather than Land's admission to the hospital having been a request on his part, it was an imperative directive from his CIGNA-approved doctors.

Petitioners go on to state that, following the discharge order from CIGNA's approval nurse, Land "did not follow his treating physicians' recommendation that he be admitted to the hospital, but instead underwent out-patient treatment," and attribute this statement to Respondent's own allegations. Pet. at 3. This incorrect statement adds to an inaccurate view that Land's hospital admission was elective, and that once it was denied he neglected his own care by failing to properly follow his physicians' directions. Such a view misapprehends the facts

as explained in the appellate court opinion, and incorrectly lends support to CIGNA's contention that the nurse's decision was simply a benefits determination, rather than a medical decision. Furthermore, nowhere in either of Respondent's complaints is any such allegation made.

2. Petitioners bemoan the fact that the Eleventh Circuit did not accord *Pilot Life Insurance Co., v. Dedeaux*, 481 U.S. 41 (1987) much weight in the determination of this case. They note that the Eleventh Circuit discussed *Pilot Life* only in a footnote, and assert that the court ignored that case's explicit holding that ERISA was the exclusive remedy for claims such as Land's. Pet. at 6. Petitioners are incorrect.

The Eleventh Circuit did not feature *Pilot Life* prominently in its decision because it determined that the case was factually inapt and CIGNA's reliance thereon was "misplaced." App. at 13a. In *Pilot Life*, the factual issue was faulty claims processing, civil actions for which were held to be completely preempted by ERISA. Because, based upon *Pegram*, the Eleventh Circuit had already concluded that CIGNA's nurse's decision was not merely a benefits determination or claims processing (explaining that this was so because treatment of cellulitis was within the coverage of Land's policy, as was hospitalization-thus, the decision to disregard Land's physicians' diagnosis and discharge Land was a medical decision), the court decided that *Pilot Life* was not dispositive as it simply did not address the issue before the court. App. at 13a.

REASONS FOR DENYING THE WRIT

In its petition, CIGNA describes the issue presented here as identical to the issue presented in *CIGNA HealthCare of Texas v. Calad*, No. 03-83 (consolidated with *Davila* and petition granted on November 3, 2003); *Aetna Health Inc. v. Davila*, No. 02-1845 (consolidated with *Calad* and petition granted on November 3, 2003); *Vytra Healthcare v. Cicio* No. 03-69 (petition filed July 11, 2003); *Conover v. Aetna U.S. Healthcare, Inc.*, No. 02-1864 (petition filed June 17, 2003), and *Roark v. Humana, Inc.*, No. 02-1826 (petition dismissed September 18, 2003). CIGNA's description, however, is not accurate. Though similar, the issue presented in *Land* is not the same as that presented in the cases noted above.

The distinction to be drawn in *Land* is that, although categorized as a mixed treatment and eligibility decision by the Eleventh Circuit, the nurse's decision to discharge Land from the hospital was only marginally, if at all, a mixed decision. In fact, the nurse's decision may be more properly be viewed as a pure medical decision, in that the nurse made an independent diagnosis (ultimately incorrect), at odds with the diagnoses of Land's two treating physicians, and opted for a treatment regimen based solely on her own negligent and incorrect belief as to the seriousness of Land's infection. At no time during the nurse's decision-making process was there any consideration by her of whether Land's treatment was a covered benefit. (It was). Rather, the nurse simply substituted her own medical (mis)judgment as to Land's proper treatment for that of Land's doctors, with disastrous results. No facts contrary to that description of the nurse's decision have been alleged or briefed

by Respondent during the course of this litigation. Under *Pegram*, the Eleventh Circuit's holding that this case is not subject to ERISA preemption is the correct decision, regardless whether that holding is based upon a mixed decision or a pure treatment decision.

The medical decision at issue in *Land* is nearly identical to the decision made in *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001) and should be treated similarly by this Court. In that case, Pappas presented to a hospital with what was determined by several examining physicians to be an epidural abscess which was pressing on Pappas' spinal column. *Id.* at 1091. Pappas' physicians characterized the abscess as a neurological emergency and immediately made arrangements to transfer Pappas to a nearby facility with the ability to care for him. *Id.* Pappas' HMO refused to approve the transfer, because the hospital to which Pappas' doctors had arranged to have him transferred was not in the HMO's network of providers. *Id.* Pappas' diagnosing doctor personally spoke with several representatives of the HMO, but was unable to gain their approval of the requested transfer. *Id.* Pappas was eventually transferred, but to a different, less capable facility. *Id.* Because of the delay in treatment and resulting compression of his spinal cord, Pappas became a permanent quadriplegic. *Id.* Pappas filed suit against the original treating hospital and his primary care physician, alleging negligence in delaying his transfer. *Id.* The hospital and the physician then filed a third party claim against the HMO, U.S. Healthcare, for denying the transfer as originally requested. *Id.*

The Pennsylvania Supreme Court first heard the case in *"Pappas I." Pappas v. Asbel*, 724 A.2d 889 (Pa. 1998). The court determined that the suit against the HMO was not preempted by ERISA, because a negligence action was not "related to" benefits under ERISA § 514. *Pappas*, 724 A.2d at 893. In reaching its decision, the court relied heavily on *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995), which was critical of the "related to" language in ERISA, as being too far-reaching.

The case was subsequently appealed to this Court. *See, United States Healthcare Sys. Of Penn., Inc. v. Penn. Hosp. Ins. Co.*, 530 U.S. 1241 (1998)(denying writ of certiorari and vacating judgment of Pennsylvania Supreme Court for reconsideration in light of *Pegram*). The Pennsylvania Supreme Court reconsidered in light of *Pegram* in *"Pappas II" See, Pappas v. Asbel*, 768 A.2d 1089, and reached the same conclusion it had during its first review of the case. The court determined that the decision not to immediately transfer Pappas to the requested facility had been a mixed treatment or medical decision within the bounds of *Pegram*. Thus, the state law claim alleging medical negligence was not preempted by ERISA. *Pappas*, 768 .2d at 1096. Following the Pennsylvania's second decision that Pappas' state claim was not preempted, the HMO again petitioned this Court for a Writ of Certiorari, which was denied. *See, U.S. Healthcare Sys. of Penn., Inc. vs. Penn. Hosp. Ins. Co.*, 563 U.S. 938 (2002) *cert. denied.*

The situation in *Pappas* was nearly identical to that in *Land*, at least as far as the nature of the decision was concerned. In *Pappas*, there was no question whether the treatment was covered. *Id.* at 1095. The only decision made was where Pappas' treatment was to be received (and, thus, what the ultimate quality and nature of that treatment was to be). *Id.* The same situation occurred in *Land*, as explained above. Therefore, the decision of the Pennsylvania Supreme Court that ERISA does not preempt state law medical negligence claims, reached in express reliance on *Pegram's* teaching (as instructed to do by this Court), is highly persuasive. *Land* and *Pappas* are siblings; as such, *Land* requires no further review from this Court.

CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be denied and the Petitioners request to hold or stay the decision pending the outcome of the Calad/Davila cases should be denied.

Respectfully submitted,

NORWOOD S. WILNER
STEPHANIE J. HARTLEY
Spohrer, Wilner, Maxwell
& Matthews, P.A.
701 West Adams Street
Jacksonville, FL 32204
(904) 354-8310
Counsel for Respondent

November 26, 2003

APPENDIX

APPENDIX A

[PUBLISH]

FILED
U.S. COURT OF APPEALS
ELEVENTH CIRCUIT
JULY 30, 2003
THOMAS K. KAHN
CLERK

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 02-15549

D. C. Docket No. 02-00470-CV-J-20

ROBBIE LEE LAND,
DONNA LAND,
Plaintiffs-Appellants,

Versus

CIGNA HEALTHCARE OF FLORIDA,
a Florida Corporation,
Defendant-Appellee.

Appeal from the United States District Court
for the Middle District of Florida

(July 30, 2003)

Before MARCUS and WILSON, Circuit Judges, and RESTANI*, Judge.

WILSON, Circuit Judge:

Robbie Lee Land appeals the district court's order denying his motion to remand and granting CIGNA Healthcare of Florida's motion to dismiss.[1] The principal issue in this case is whether Land's state law malpractice claims against his health maintenance organization (HMO) were preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001–1461. We conclude that they were not preempted, and, therefore, we vacate and remand to the district court with instructions to remand this case to state court.

BACKGROUND

Land was a subscriber through his employer to a health care plan administered as an HMO by CIGNA. On January 14, 2001, Land was bitten on his left hand by his family cat. Later that afternoon, he noticed that his hand had become swollen and inflamed, and the next day he sought treatment at a hospital emergency room where he was treated by Dr. John C. Crick, a CIGNA-approved hand specialist. Dr. Crick diagnosed him with cellulitis, ordered that he be given an injection of antibiotics in the emergency room, and prescribed an additional course of antibiotics to treat the infection. Dr. Crick reevaluated Land's hand the following day and found no improvement in his condition. As he

---

* Honorable Jane A. Restani, Judge, United States Court of International Trade, sitting by designation.

[1] Donna Land, Land's wife, also appeals the district court's order as it pertains to the dismissal of her joint state law claim for the loss of her husband's services, comfort, society, and attention. Because we vacate the order in its entirety, it is not necessary to address her claims separately.

observed that Land's hand still was swollen and that there was limitation of motion in the joints, Dr. Crick began to suspect that Land was suffering from osteomyelitis, a more serious infection than cellulitis.

In developing a course of treatment for the infection, Dr. Crick conferred with Dr. David Gouch, Land's primary care physician. After consulting with each other, the physicians ordered that Land be admitted into the hospital immediately for aggressive intravenous antibiotic treatment and constant monitoring and assessment of his infection to determine whether surgery or modified antibiotic treatment would be necessary. Land was admitted into the hospital that same day and placed on intravenous antibiotics.

Land alleges that shortly after his admission into the hospital, a CIGNA approval nurse reviewed the proposed plan of treatment for his infection. The nurse approved the use of intravenous antibiotic therapy, but determined that he was suffering from a localized infection that did not require hospitalization. The nurse thus decided that the treatment should be provided on an outpatient basis in Land's home rather than on an inpatient basis in the hospital, and Land was discharged that evening.

By the following week, Land's condition had worsened considerably, and he developed an abscess extending into the joint between his hand and middle finger. Outpatient surgery was performed to drain, irrigate, and debride the metacarpophalangeal joint of his hand. A pathology report on the removed tissue revealed that Land was suffering from severe chronic inflammation, focal necrosis, and the presence of Pasteurella multocida, an organism that can cause serious infection and even death. When his condition failed to improve, Land underwent a second surgery, and, following that operation, he was diagnosed with osteomyelitis of the third metacarpal of the left hand. The condition of Land's hand continued to

deteriorate over the course of the next few weeks, and he underwent additional surgeries to debride his metacarpal bone and totally replace his metacarpophalangeal joint. None of those surgeries successfully repaired the damage caused by the infection, however, and, ultimately, his middle finger had to be amputated.

After losing his finger, Land filed suit against CIGNA in state court, alleging that CIGNA was negligent in the care and treatment of his infection. CIGNA removed the case to federal court, asserting that Land's claims implicated ERISA and therefore raised a federal question. Land moved to remand the case to state court, but the district court denied that motion and granted CIGNA's motion to dismiss Land's complaint without prejudice, determining that his state law claims were completely preempted by ERISA. Land filed an amended complaint, which also was dismissed without prejudice, and, shortly thereafter, he filed this appeal.

STANDARD OF REVIEW

"We review *de novo* the district court's grant of a motion to dismiss under [Federal Rule of Civil Procedure] 12(b)(6) for failure to state a claim, accepting the allegations in the complaint as true and construing them in the light most favorable to the plaintiff." [2] 2 *Hill v. White*, 321 F.3d 1334, 1335 (11th Cir. 2003) (per curium). We also review the denial of a motion to remand de novo. *See Butero v. Royal Maccabees Life Ins. Co.*, 174 F.3d 1207, 1211 (11th Cir.

[2] Although the district court did not state in its order that it was granting CIGNA's motion to dismiss for failure to state a claim pursuant to Rule 12(b)(6), we assume that the court granted the motion on this ground based upon CIGNA's affirmative defense that Land's claims were subject to federal preemption. *See Quiller v. Barclays Am./Credit, Inc.*, 727 F.2d 1067, 1069 (11th Cir. 1984) (recognizing that the affirmative defense of federal preemption can be the basis of a Rule 12(b)(6) motion).

1999). "We review *de novo* the district court's ERISA preemption analysis." *Hall v. Blue Cross/Blue Shield of Ala.*, 134 F.3d 1063, 1064–65 (11th Cir. 1998).

DISCUSSION

Essentially, this case is reduced to a jurisdictional issue – whether the district court had original jurisdiction over Land's claims, thereby making removal proper, or whether the court lacked jurisdiction and should have remanded the case to state court. Land argues that because his claims were state law malpractice claims, they were not preempted by ERISA and the district court therefore should have granted his motion to remand. CIGNA, however, argues that Land's malpractice claims were claims challenging the denial of benefits and thus were completely preempted by ERISA.

"A defendant may remove a case to federal court only if the district court would have had jurisdiction over the case had the case been brought there originally. A federal district court has original jurisdiction over diversity cases and cases arising under federal law." *Kemp v. Int'l Bus. Machs. Corp.*, 109 F.3d 708, 711–12 (11th Cir. 1997) (citation omitted). In this case, there was no diversity between the parties, so the district court had jurisdiction over the action only if it was based upon a matter arising under federal law. *See* 28 U.S.C. § 1331.

"Ordinarily, a cause of action does not arise under federal law unless the plaintiff's well-pleaded complaint presents a federal question." *Hall*, 134 F.3d at 1065 (internal quotation marks omitted). We have recognized, however, that

> there is a qualification to the well-pleaded complaint rule: a doctrine known as "complete preemption" or "super

> preemption." Under that doctrine, Congress may preempt an area of law so completely that any complaint raising claims in that area is necessarily federal in character and therefore necessarily presents a basis for federal court jurisdiction.

Kemp, 109 F.3d at 712. Although super preemption is exceedingly rare, the United States Supreme Court has held that Congress created such preemption in section 502(a) of ERISA, 29 U.S.C. § 1132(a), and, therefore, all "causes of action within the scope of the civil enforcement provisions of § 502(a) [are] removable to federal court." *See Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 65–66 (1987). Thus, if Land seeks relief that is available under section 502(a), there was federal question jurisdiction and removal of his case to district court was appropriate. If he did not seek such relief, however, the district court had no jurisdiction over his claims and remand to state court was required. Section 502(a)(1)(B) provides that an ERISA plan "participant or beneficiary" may bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). Therefore, to determine whether Land seeks relief under section 502(a)(1)(B), we must consider whether his claims fall within the scope of one of those three categories. As we do not believe that Land's claims can be characterized as claims seeking "to clarify his rights to future benefits" or "to enforce his rights under the terms of [his health care] plan," they must be considered claims "to recover benefits" that were denied when the approval nurse decided not to authorize inpatient treatment for his infection to fall under section 502(a)(1)(B) and thereby be completely preempted. *Id.*

We cannot ascertain whether Land's claims are claims seeking to recover benefits without first determining what type of decision the approval nurse made when she denied authorization of inpatient treatment for Land's infection. CIGNA contends that this merely was an eligibility[3] decision pertaining to Land's benefits under the plan, but Land asserts that it was a treatment decision relating to the actual care of his infection. In resolving this issue, we rely heavily upon the Supreme Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000).

In *Pegram*, the Court held that a patient could not state a claim against her HMO under section 502(a)(2) based upon her physician's malpractice, because the HMO did not act "as a fiduciary to the extent that it ma[de] mixed eligibility decisions acting through its physicians." *Id.* at 231. The plaintiff, Cynthia Herdrich, became Dr. Lori Pegram's patient through her HMO, which was owned and operated by a group of physicians that included Dr. Pegram. *Id.* at 215. After examining Herdrich, Dr. Pegram discovered that a mass in her abdomen was inflamed, but rather than order an immediate ultrasound at a local facility, she made Herdrich wait eight days until the ultrasound could be performed at a facility more than fifty miles away. *Id.* During that period, Herdrich's appendix ruptured, and, as a result, she sued Dr. Pegram and the HMO for medical malpractice under state law and for breach of fiduciary duty pursuant to section 502(a)(2), alleging that the physicians' ownership of the HMO created an incentive to make decisions in their self-interest rather than in the interests of the plan participants. *Id.* at 215–16.

In addressing the merits of Herdrich's claims, the Court first acknowledged the unique way in which HMOs

---

[3] Courts have used the terms "eligibility" and "coverage" interchangeably, but for the sake of clarity, we hereinafter refer to these types of decisions as eligibility decisions.

operate, noting that to control costs, "they commonly require utilization review (in which specific treatment decisions are reviewed by a decision maker other than the treating physician) and approval in advance (precertification) for many types of care, keyed to standards of medical necessity or the reasonableness of the proposed treatment." *Id.* at 219. The practices of utilization review and precertification require HMOs to make decisions that blur the lines between an HMO's role as an ERISA fiduciary and its role as a health care provider. *See id.*

In its effort to characterize the substance of Herdrich's claims, the Court acknowledged the difficulty of distinguishing between the dual medical and administrative roles of HMOs and identified the following types of HMO decisions: eligibility decisions, treatment decisions, and mixed eligibility and treatment decisions. *Id.* at 228–29. The differences between these types of decisions were explained as follows:

> What we will call pure "eligibility decisions" turn on the plan's coverage of a particular condition or medical procedure for its treatment. "Treatment decisions," by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?
>
> These decisions are often practically inextricable from one another . . . . This is so not merely because, under a scheme like [the utilization review process in this case], treatment and eligibility decisions are made by the same person, the treating physician. It is so because a great many and possibly most coverage questions are not simple yes-or-no questions, like whether appendicitis is a covered condition (when there is no dispute that a patient has appendicitis), or whether acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged). The more common coverage question is a when-and-how question. Although coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians still must decide what to do in particular cases. The issue may be, say, whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement that conditions the HMO's obligation to provide or pay for that particular procedure at that time in that case. . . . In practical terms, these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment . . . . The eligibility decision and the treatment decision [a]re inextricably mixed, as they are in countless medical administrative decisions every day. *Id.*

The Court thus concluded that Dr. Pegram's decision was a mixed eligibility and treatment decision, which was not fiduciary in nature and therefore did not state a claim for breach of fiduciary duty under section 502(a)(2). *See id.* at 231, 237.

Although *Pegram* is not dispositive because the issue of preemption was not before the Court, we find compelling persuasive force in the Court's unanimous ruling and believe

that it provides us with guidance in determining the true nature of Land's claims. Thus, with *Pegram*'s description of the three types of HMO decisions in mind, we turn to the question of whether the approval nurse's decision to authorize outpatient rather than inpatient treatment of Land's infection was an eligibility decision, a treatment decision, or a mixed decision. To answer this question, we must parse the allegations of Land's amended complaint. *See id.* at 227.

We believe that the crux of Land's claim is found in the following allegations of the amended complaint:

> 16. Although Defendant, CIGNA, approved the intravenous antibiotic therapy benefits to the Plaintiff, CIGNA's approval nurse made a medical decision that the intravenous therapy should be provided on an "out-patient" basis in Plaintiff's home instead of as an "in-patient" at St. Vincent's Medical Center.
>
> 17. This CIGNA approval nurse based her medical decision for treatment on her classification of the wound as a localized infection rather than the correct diagnosis made by Dr. Crick of cellulitis (a widespread, non-localized infection.)[.]
>
> 18. Defendant's substitution of a lower quality of care ("outpatient" therapy as opposed to "in-patient" therapy,) was the direct and proximate cause of the failure to timely and appropriately treat the Plaintiff's ongoing, widespread infection, as more specifically set forth in the allegations below.
>
> 19. The Defendant, CIGNA, in its capacity as a health care provider, had a duty to

> provide appropriate medical treatment under the prevailing standard of medical care in Florida, and assumed the duty when the approval nurse made her diagnosis and treatment decision.
>
> 20. On January 16, 2001, Defendant, CIGNA, made a negligent diagnosis and negligent treatment decision when the approval nurse elected to have Plaintiff treated in his home for a localized infection, rather than at St. Vincent's Medical Center for cellulitis (the correct diagnosis).

Taking these allegations as true, as we are required to do when considering the dismissal of a complaint, *see Hill*, 321 F.3d at 1335, we conclude that the approval nurse made a mixed eligibility and treatment decision, because the decision was not a simple yes-or-no eligibility determination about whether CIGNA would cover treatment for cellulitis; rather, the eligibility decision was intertwined with the approval nurse's medical decision that inpatient treatment of Land's infection was unnecessary. Indeed, Land alleges that inpatient treatment of his infection would have been covered had the approval nurse correctly determined that he was suffering from cellulitis rather than a localized infection. Based upon that allegation, we believe that the approval nurse "made a patient-specific prescription of appropriate treatment by denying one treatment and authorizing another." *Cicio v. Does*, 321 F.3d 83, 104 (2d Cir. 2003).

This is just the kind of decision about "the reasonableness of a certain treatment, and the emergency character of a medical condition" that the Supreme Court has identified as a mixed eligibility and treatment decision. *See Pegram*, 530 U.S. at 230. Land's allegations thus can be analogized to the way Herdrich's physician decided (wrongly, as it turned out) that Herdrich's condition did not

warrant immediate action; the consequence of that medical determination was that [the HMO] would not cover immediate care, whereas it would have done so if Dr. Pegram had made the proper diagnosis and judgment to treat. *Id.* at 229. Therefore, because the approval nurse made a medical decision that inpatient care was not "so superior . . . under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement that conditions the HMO's obligation to provide or pay for that particular procedure at that time in that case," we find that the decision was a mixed decision. *Id.*

Having determined that Land's malpractice claims were not based upon a pure eligibility decision, but rather upon a mixed decision of eligibility and treatment, we must consider whether mixed decision claims are claims "to recover benefits" under section 502(a)(1)(B) and therefore completely preempted. Once again, we find the reasoning of *Pegram* persuasive. In reaching its conclusion that an HMO does not act as a fiduciary when it makes a mixed eligibility and treatment decision, the Court reiterated its prior holding "that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Id.* at 237. The Court therefore expressed strong doubt that Congress intended to federalize and preempt state law malpractice claims by converting them to fiduciary claims under section 502(a)(2) or to "apply[] an ERISA standard of reasonable medical skill."[4] *Id.* at 236. In our view, it makes little sense to believe that Congress did not intend to federalize

---

[4] Although the Court expressed doubt that Congress intended for ERISA to preempt medical malpractice claims, it was not called upon to decide the issue of preemption in that case and therefore declined to consider whether Herdrich could have stated a claim under section 502(a)(1)(B) to recover benefits, or whether her state law malpractice claim was preempted by section 502(a)(1)(B). *See Pegram*, 530 U.S. at 229 n.9.

malpractice claims under section 502(a)(2), but intended to do so under section 502(a)(1)(B).

Indeed, our own precedent casts doubt upon the idea that section 502(a)(1)(B) preempts medical malpractice claims. As that section allows a plan beneficiary or participant "to recover benefits due to him under the terms of his plan," ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), we have held that claims seeking to recover benefits under section 502(a)(1)(B) essentially are contract claims, *see Harrison v. Digital Health Plan*, 183 F.3d 1235, 1241 (11th Cir. 1999) (per curiam) (finding that "an employer's obligation to provide medical benefits under an ERISA plan is contractual. A plaintiff's action to enforce the medical benefits provision of a self-funded ERISA plan is essentially a lawsuit by an employee against her employer for breach of contract" (citation omitted).); *see also Horton v. Reliance Standard Life Ins. Co.*, 141 F.3d 1038, 1040 (11th Cir. 1998) (per curiam) ("A plaintiff suing under [section 502(a)(1)(B)] bears the burden of proving his entitlement to contractual benefits."). In this case, however, we do not believe that Land's claims can be characterized as contract claims, because he does not allege that he was denied medical benefits and he does not seek reimbursement for his medical expenses; rather, he claims that the HMO's failure to diagnose his condition correctly and authorize the proper medical treatment resulted in the loss of his finger. Land's claims, therefore, are tort claims based upon the duty of care rather than contract claims based solely upon a denial of benefits.[5]

---

[5] Because we find that Land is not challenging a denial of benefits, we believe that CIGNA's reliance upon the Supreme Court's decision in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), is misplaced. In that case, the Court held that "the civil enforcement scheme of ERISA makes clear its intention that all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions governed by § 502(a)." *Id.*

As a result, Land's claims do not fall "within the scope of the civil enforcement provisions of § 502(a)," *Taylor*, 481 U.S. at 66, and thus are not completely preempted.[6] Therefore, Land's complaint did not present a

---

at 56. The plaintiff in that case challenged his insurance company's termination of his disability benefits, asserting state law claims for breach of contract, breach of fiduciary duty, and fraud in the inducement. *Id.* at 43. The Court held that "§ 502(a) [was intended to] be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits" and thus concluded that the plaintiff's state law claims were preempted. *Id.* at 52. As we do not believe that Land's malpractice action is based solely upon the improper processing of a claim, *Pilot Life Insurance Co.* does not foreclose our holding in this case.

[6] We therefore reach the same result as the Second and Fifth Circuits. *See Cicio*, 321 F.3d at 102 ("conclud[ing] that a state law malpractice action, if based on a mixed eligibility and treatment decision, is not subject to ERISA preemption when that state law cause of action challenges an allegedly flawed medical judgment as applied to a particular patient's symptoms" (internal quotation marks omitted)); *Roark v. Humana, Inc.*, 307 F.3d 298, 309 (5th Cir. 2002) (finding that "ERISA provides no cause of action for medical malpractice claims against an HMO" and that such claims therefore are not preempted by section 502(a)(1)(B)), *petition for cert. filed*, 71 U.S.L.W. 3791 (U.S. June 3, 2003) (No. 02-1826).

We find additional support for our holding in decisions of the Fourth and Third Circuits, which cited *Pegram* with approval, but nevertheless concluded that the plaintiffs' claims were preempted. *See Marks v. Watters*, 322 F.3d 316, 324, 327 (4th Cir. 2003) (recognizing *Pegram*'s teaching that "mixed eligibility and treatment decisions as a practical matter reduce to the stuff of State malpractice claims and not to traditional breach of fiduciary duty claims," but determining that the plaintiff's HMO did not make a treatment determination when the decision to release him from psychiatric care was made solely by his physician and the HMO case manager had no input in that decision); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 274 (3d Cir. 2001) (citing *Pegram* with approval and reiterating the validity of its prior holdings that state law claims are not preempted when "the HMO . . . assume[s] the dual role of an administrator of benefits and a provider of medical services," but finding that the plaintiff's claims "[we]re limited to [the HMO's] delay in approving benefits, conduct falling squarely within [the] administrative function").

federal question and removal jurisdiction was inappropriate. The district court thus lacked subject matter jurisdiction over this case and remand to state court was required.[7]

CONCLUSION

Based upon the foregoing, we VACATE the district court's order granting the motion to dismiss and REMAND to the district court with instructions to REMAND this case to state court.

---

[7] Our decision that Land's claims are not subject to complete preemption does not end the preemption inquiry, because his claims still may be subject to defensive preemption (also known as conflict preemption) under section 514(a) of ERISA, 29 U.S.C. § 1144(a). *See Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997) (per curiam) (holding that under section 514, a state law claim is subject to "ERISA preemption whenever the alleged conduct at issue is intertwined with the refusal to pay benefits"). Because the district court does not have jurisdiction over this case, however, this will be a matter for the state court to decide upon remand, and our decision today should not be read to express any opinion as to whether Land's claim is conflict preempted. *See Kemp*, 109 F.3d at 714 (noting that if a federal court lacks jurisdiction, it "cannot decide a preemption defense").

APPENDIX B

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

ROBBIE LEE LAND and
DONNA LAND,

Plaintiffs,

v. Case No.: 3:02-cv-470-J-20HTS

CIGNA HEALTHCARE OF FLORIDA,
a Florida Corporation,

Defendant.

ORDER

This cause is before the Court on Defendant's Motion to Dismiss (Doc. No. 3, filed in state court May 2, 2002), Plantiffs' Motion for Remand, Attorney's Fees and Costs (Doc. No. 6. filed May 28, 2002), and Defendant's Response in Opposition to Plaintiffs' Motion for Remand (Doc. No. 7, filed June 12, 2002).[1]

I. Background

Plaintiffs originally filed this action in state court on April 9, 2002. Defendant subsequently removed to this Court on May 16, 2002 under 28 U.S.C. § 1446, asserting that Plaintiffs' state law tort claims are completely preempted by the Employee Retirement Income Security Act

---

[1] Although Plaintiff did not file a response to the Motion to Dismiss, its Motion for Remand is generally responsive to the argument's raised in Defendant's Motion.

of 1974 ("ERISA"), 29 U.S.C. § 1001, et seq. Defendant's Motion to Dismiss, filed in state court, was based on the same argument.

Defendant is alleged to be a licensed Health Maintenance Organization ("HMO") that provided a health plan to which Plaintiff subscribed. According to the Complaint, Plaintiff Robbie Lee Land was bitten on the left hand by his family cat on January 14, 2001. On January 15, 2001, Land's hand became inflamed and he sought treatment at St. Vincent's Medical Center emergency room. He was treated by Dr. John C. Crick, a hand specialist approved by Defendant, and released. On January 16, 2001, Land's condition became worse and he was re-examined by Dr. Crick, who suspected that the inflammation was caused by osteomyelitis, a condition associated with infection of bone marrow or bone structures. Dr. Crick conferred with Land's primary care physician and ordered immediate hospital admission. Plaintiffs allege that despite the doctor's recommendation, Defendant refused to cover the costs of Land's hospital admission. Land subsequently underwent a series of surgeries on his hand, culminating in a procedure to amputate his left middle finger.

The Complaint alleges negligence in Defendant's alleged failure to :properly evaluate and approve treatment of Plaintiff's suspected osteomyelitis; follow Dr. Crick's order for in-patient admission; and adequately evaluate Land's medical status. These negligent acts or omissions are alleged to be the proximate cause of Land's injuries. Additionally, Plaintiff Donna Land, Robbie Lee Land's wife, has filed a derivative claim for loss of consortium.

II. Discussion

Motion to Remand

Turning first to the Motion for Remand, the removing party, i.e., Defendant, bears the burden of showing the

existence of federal jurisdiction, and doubts regarding the existence of jurisdiction are to be resolved in favor of the non-removing party. *See Pacheco de Perez v. AT&T Co.*, 139 F.3d 1368, 1373 (11th Cir. 1998). Moreover, the removal statutes are strictly construed against the exercise of federal jurisdiction. *See Butler v. Polk*, 592 F.2d 1293, 1296 (5th Cir. 1979).[2]

Complete Preemption

ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the Act. 29 U.S.C. § 1144(a). *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S 41 (1987); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); *National Companies Health Plan v. St. Joseph's Hosp.*, 929 F.2d 1558 (11th Cir. 1991). The phase "relate to" as used in ERISA is defined broadly, and requires complete preemption of common law tort claims based on an alleged denial of benefits. *See Pilot Life*, 481 U.S. at 56; *Butero v. Royal Maccabees Life Ins. Co.*, 174 F.3d 1207, 1212 (11th Cir. 1999)[3]

Plaintiffs argue that Defendant's alleged refusal to cover Land's hospital stay was not merely a denial of benefits, which Plaintiffs acknowledge would be preempted under ERISA. Rather, they argue that it was a "mixed" eligibility and treatment decision. According to Plaintiffs, the Supreme Court's holding in *Pegram v. Herdrich*, 530 U.S. 211 (2000) stands for the proposition that such "mixed" decisions do not implicate ERISA preemption. Plaintiffs'

---

[2] All cases decided by the former Fifth Circuit Court of Appeals prior to the close of business on September 30, 1981, are binding on the Eleventh Circuit and on all district courts within the Eleventh Circuit. *See Bonner v. City of Prichard*, 661 F.2d 1206, 1207 (11th Cir. 1981) (en banc).

[3] When an area of state law has been completely preempted, this Court may maintain subject matter jurisdiction even though Plaintiff's Complaint only refers to state law claims. *See BLAB T.V. of Mobile, Inc. v. Comcast Cable Comm., Inc.*, 182 F.3d 851, 854 (11th Cir. 1998).

argument both confuses and overstates the holding in *Pegram*. *Pegram* involved a claim against an HMO for breach of fiduciary duty under ERISA where the HMO was owned by its participating physicians who stood to earn greater profits by limiting medical care. The plaintiff in *Pegram* alleged that her physician, an owner of the HMO, negligently delayed performing an ultrasound of her inflamed abdomen until the procedure could be performed at a more distant hospital, where presumably it would cost less. The Supreme Court noted that the physician's decision on how to treat the plaintiff's symptoms was a mixed treatment and eligibility decision, and that such mixed decisions did not implicate the physician's fiduciary status as an owner of the HMO. Consequently, the plaintiff could not state a claim for breach of fiduciary duty under ERISA. *Id.* at 237.

In contrast to *Pegram*, Defendant's fiduciary status is not at issue here. Perhaps more to the point, Defendant is not alleged to have made any *treatment* decisions, and Plaintiffs are not complaining about the *quality* of a benefit or attempting to hold Defendant vicariously liable for medical malpractice. Rather, they complain about negligent administration of an ERISA plan in the Defendant's refusal to provide benefits. Such claims have been held to be completely preempted under ERISA. *See Krasny v. Waser*, 147 F. Supp.2d 1300, 1307 (M.D. Fla. 2001); *Dearmas v. Av-Med, Inc.*, 865 F.Supp. 816, 818 (S.D Fla. 1994); *Ashburn v. Dorado*, Case No.: 8:01-cv-381-T-17TBM (M.D. Fla. March 8, 2002). Accordingly, the Court holds that Plaintiffs' tort claims are completely preempted by ERISA, and this Court has subject matter jurisdiction over this case.

Motion to Dismiss

As noted above, Defendant moved to dismiss this case in state court on the same grounds as it opposes remand, i.e., that Plaintiffs' claims are completely preempted. As

indicated above, the Court agrees, and Plaintiffs' tort claims are dismissed.

III. Conclusion

For the reasons stated herein, it is **ORDERED** that:

Plaintiffs' Motion for Remand, Attorney's Fees and Costs (Doc. No. 6, filed May 28, 2002) is **DENIED.** Defendant's Motion to Dismiss (Doc. No. 3, filed in state court May 2, 2002) is **GRANTED**. This case is **DISMISSED WITHOUT PREJUDICE**. Plaintiffs may file an Amended Complaint that re-pleads their case under ERISA no later than **thirty (30) days** from the date of this Order.

DONE AND ENTERED at Jacksonville, Florida, this 8th day of July, 2002.

/s/ Harvey E. Schlesinger
HARVEY E. SCHLESINGER

Copies to:

Stephanie J. Hartley, Esq.
J. Charles Ingram, Esq.
Garry Randolph, Courtroom Deputy
Law Clerk

APPENDIX C

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

ROBBIE LEE LAND and
DONNA LAND,

Plaintiffs,

v. Case No.:3:02-cv-470-J-20HTS

CIGNA HEALTHCARE OF FLORIDA,
a Florida corporation,

Defendant.

ORDER

This cause is before the Court on Defendant's Motion to Dismiss Plaintiffs' Amended Complaint (Doc. No. 20, filed August 14, 2002). On July 8, 2002, the Court issued an order (Doc. No. 11, filed July 9, 2002) dismissing Plaintiffs' complaint without prejudice and allowing Plaintiffs to file an amended complaint, pleading their case under ERISA. Plaintiffs' Amended Complaint (Doc. No. 19, filed August 7, 2002) does not plead their case under ERISA. Accordingly, for the reasons stated in the July 8th Order, Defendant's Motion to Dismiss is **GRANTED**, and Plaintiffs' amended complaint is **DISMISSED WITHOUT PREJUDICE**. Plaintiffs may file an Amended Complaint that re-pleads their case under ERISA no later than **thirty (30) days** from the date of this Order.

DONE AND ENTERED at Jacksonville, Florida, this 11th day of September, 2002.

/s/ Harvey E. Schlesinger

HARVEY E. SCHLESINGER

Copies to:

Stephanie J. Hartley, Esq.
J. Charles Ingram, Esq.
Garry Randolph, Courtroom Deputy

APPENDIX D

TITLE 29 – LABOR
CHAPTER 18 – EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER 1 – PROTECTION FO EMPLOYEE BENEFIT RIGHTS
SUBTITLE A—GENERAL PROVISIONS

* * * * * *

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), or (7) of subsection (c) of this section or under subsection (i) or (l) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) of this section with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if--

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(3) The Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 1191b(a)(1) of this title). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e)(1) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single

participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021(e)(2) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 for each violation by any person of section 1021(f)(1) of this title.

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 1021(g) of this title.

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 1024(a)(6) of this title, the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary may assess a civil penalty against a plan administrator of up to $100 a day from the date of the plan administrator's failure or refusal to provide notice to participants and beneficiaries in accordance with section 101(i). For purposes of this paragraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(8) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1320b-14(c)(8) of Title 42.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of

this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan--

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of--

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon Secretary of Labor and Secretary of the Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of Title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of Title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a

transaction with respect to a plan described in section 4975(e)(1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor

Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(*l*) Civil penalties on violations by fiduciaries

(1) In the case of--

(A) any breach of fiduciary responsibility under (or other violation of) part 4 of this subtitle by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)--

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that--

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9) of this section) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of Title 26.

(m) Penalty for improper distribution

In the case of a distribution to a pension plan participant or beneficiary in violation of section 1056(e) of this title by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

* * * * *

§ 1144. Other Laws

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section--

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements

under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section-

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides--

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple

employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) of this section shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title), qualified medical child support orders (within the meaning of section 1169(a)(2)(A) of this title), and the provisions of law referred to in section 1169(a)(2)(B)(ii) of this title to the extent they apply to qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action--

(A) with respect to which the State exercises its acquired rights under section 1169(b)(3) of this title with respect to a group health plan (as defined in section 1167(1) of this title), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act [42 U.S.C. § 1396 et seq.] which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 1191 of this title.

(c) Definitions. For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of

any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(c) of this title) or any rule or regulation issued under any such law.